

UNIFORM SUSPECTED INSURANCE FRAUD REPORTING FORM

State of West Virginia
Office of the Insurance Commissioner
Fraud Division

For State Use Only

Case No.

Status

FYI

Reporting Person:	Insurance Company:	NAIC#
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Mailing address:	Phone number: ()
	Fax number: ()
	E-mail address:

Detailed synopsis. Attach additional pages, if necessary.

Date of Loss / Injury:	Dates of Service: to
Address of Loss / Injury:	Description of Service:
(City) (State) (Zip)	

Claim #	Policy #
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Reserve Amount \$	Amount Paid \$	Date Paid	Procedure Code #'s: <input type="checkbox"/> CPT <input type="checkbox"/> CDT	Insurance Type <input type="checkbox"/> PC <input type="checkbox"/> WC <input type="checkbox"/> HC <input type="checkbox"/> Auto <input type="checkbox"/> Life <input type="checkbox"/> Disability
Loss Amount \$	Settlement Amt. \$	Date Paid	Civil Litigation Pending: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Subject Information

Type:	Name (Last / Business):	(First):	(Middle):	Date of birth:	Age:	SSN:
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Street Address (include P.O. Box and apartment #'s):	Address Type: <input type="checkbox"/> Res. <input type="checkbox"/> Bus. <input type="checkbox"/> Maildrop <input type="checkbox"/> Other	Fed. TIN <input type="checkbox"/>	EIN <input type="checkbox"/>	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
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City:	State:	Zip:	County:	Telephone No.: ()	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.
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Driver's License #:	State:	VIN:	Telephone No.: ()	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.
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Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:
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Employer:	Address & Phone #:	Occupation:
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Additional Party Involved <input type="checkbox"/> See Additional Party Involved/AKA Information	Comments:
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Case Details (check all that apply)

SIU Investigation Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Completed:
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Is there any reason to believe that this incident is related to other suspected fraudulent activity? ☐ Yes ☐ No

<input type="checkbox"/> Statements (Witness / Insured / Subject) <input type="checkbox"/> Sworn <input type="checkbox"/> Recorded <input type="checkbox"/> Proof of Loss <input type="checkbox"/> Continuance of Disability Forms <input type="checkbox"/> Medical Records <input type="checkbox"/> Other	<input type="checkbox"/> EUO / Deposition <input type="checkbox"/> Copies of Receipts <input type="checkbox"/> Expert Reports <input type="checkbox"/> Videos / Photos <input type="checkbox"/> Claim Information <input type="checkbox"/> Other	<input type="checkbox"/> Law Enforcement / Other Agency Reports <input type="checkbox"/> Claim History Extracts <input type="checkbox"/> IME Reports <input type="checkbox"/> Investigative Reports <input type="checkbox"/> External Database results <input type="checkbox"/> Other
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Identify Other Agency You Have Contacted Regarding This Referral

Agency Type: ☐ Other State Fraud Bureau ☐ Law Enforcement ☐ Other Insurance Company ☐ Regulatory Agency ☐ Other

Agency: _____	Contact Person: _____
(Address) _____ (City) _____	(State) _____ (Zip) _____
Telephone () _____	Fax () _____ Case/Claim No. _____

Suspected Fraud Types (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Arson
<input type="checkbox"/> home <input type="checkbox"/> vehicle <input type="checkbox"/> business
<input type="checkbox"/> Fictitious loss <input type="checkbox"/> damages <input type="checkbox"/>
<input type="checkbox"/> Fictitious theft
<input type="checkbox"/> vehicle <input type="checkbox"/> property
<input type="checkbox"/> Inflated inventory
<input type="checkbox"/> Inflated loss <input type="checkbox"/> damages <input type="checkbox"/>
<input type="checkbox"/> Inflated theft
<input type="checkbox"/> vehicle <input type="checkbox"/> property
<input type="checkbox"/> Double-dipping
<input type="checkbox"/> Exaggerated injuries
<input type="checkbox"/> Injuries not related to work
<input type="checkbox"/> Malingerers
<input type="checkbox"/> Misappropriated vehicle salvage
<input type="checkbox"/> Premium avoidance
<input type="checkbox"/> Prior injuries
<input type="checkbox"/> Slip and fall
<input type="checkbox"/> Staged injury / accident at work
<input type="checkbox"/> Staged collisions
<input type="checkbox"/> Paper accidents
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Agent fraud
<input type="checkbox"/> Application fraud
<input type="checkbox"/> Billing for services/products not provided
<input type="checkbox"/> Failure to disclose multiple insurance companies
<input type="checkbox"/> False claims
<input type="checkbox"/> Illegal solicitation (cappers)
<input type="checkbox"/> Issued fraudulent insurance policies, certificates, binders, ID cards
<input type="checkbox"/> Misrepresentation of services / products provided
<input type="checkbox"/> Kickbacks/bribery
<input type="checkbox"/> Money laundering
<input type="checkbox"/> Multiple claims
<input type="checkbox"/> Possession/sold fraudulent insurance policies, certificates, binders, ID cards
<input type="checkbox"/> Questioned documents
<input type="checkbox"/> altered <input type="checkbox"/> forged <input type="checkbox"/> falsified
<input type="checkbox"/> duplicated
<input type="checkbox"/> Received compensation for referral to health care provider or attorney
<input type="checkbox"/> Ring / organized activity type | <input type="checkbox"/> Duplicate billing for same service
<input type="checkbox"/> Forged prescriptions
<input type="checkbox"/> Fraudulent death claims
<input type="checkbox"/> Over-utilization of services
<input type="checkbox"/> Prescription abuse / doctor shopping
<input type="checkbox"/> Prescriptions issued for non-medical purposes
<input type="checkbox"/> Unbundling
<input type="checkbox"/> Upcoding
<input type="checkbox"/> Misrepresented non-covered services as covered
<input type="checkbox"/> Changing dates of service, CPT/CDT/diagnostic codes
<input type="checkbox"/> Charges inconsistent with services provided
<input type="checkbox"/> Products billed are inconsistent with the products
<input type="checkbox"/> Using unqualified/unlicensed persons to perform billable services
<input type="checkbox"/> Other _____ |
|--|---|--|

Subject / Additional Party Types

CL Claimant IN Insured WT Witness LC Lawyer for Claimant LI Lawyer for Insured INS Insurer SI Self-Insured IY Insurance Company Employee IB Agent/Broker IS Adjuster IR Appraiser BS Body Shop SY Salvage Yard Owner / Employee TY Tow Yard Owner / Employee MD Medical Doctor DO Doctor of Osteopathic Medicine DEN Dentist	PH Pharmacist CHI Chiropractor NP Nurse Practitioner LPN Licensed Practical Nurse PT Physical Therapist PA Physician's Assistant OP Optometrist PO Podiatrist RD Radiologist MT Massage Therapist AMB Ambulance Service Employee DME DME Supplier HHA Home Health Agency MR Laboratory MH Medical Clinic/Hospital MZ Office Administrator BS Billing Services	TPA Third Party Administrator FP False Provider UP Unlicensed Provider MN Other Medical Personnel MS Medical Specialist DS _____ Dental Specialist NS _____ Nurse Specialist OT _____ Other _____
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Chapter 33, Article 41 Code of W. Va.: Insurance Fraud Prevention Act
Fraud Division
West Virginia Office of the Insurance Commissioner
1124 Smith Street
Charleston, WV 25305
(304)558-2100 x133
(888)TRY-WVIC

Additional Party Involved / AKA Information

Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):			Address Type: <input type="checkbox"/> Res. <input type="checkbox"/> Bus. <input type="checkbox"/> Maildrop <input type="checkbox"/> Other		Fed. TIN <input type="checkbox"/> EIN <input type="checkbox"/> Number:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
City:		State:	Zip:	County:	Telephone No.: ()	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.
Driver's License #:		State:	VIN:		Telephone No.: ()	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.
Vehicle Year:	Make:	Model:		License Plate #:	Reported Injuries:	
Employer:		Address & Phone #:			Occupation:	
Involvement in referral:						

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Vehicle Year:	Make:	Model:		License Plate #:	Reported Injuries:	
Employer:		Address & Phone #:			Occupation:	
Involvement in referral:						